Mental Health Rehabilitation and Targeted Case Management (SB58)

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Agenda

- Overview
- Authorizations
- Mental Health Rehabilitative and Targeted Case Management Services
- Claims Filing
- Provider Resources
- Superior HealthPlan Departments
- Questions and Answers

Overview

What is Senate Bill 58?

- Texas Legislation which integrates in the Medicaid Managed Care program the following services for Medicaid-eligible persons:
  - Behavioral health services, including Targeted Case Management (TCM) and Mental Health Rehabilitation (MHR) services.
  - Physical health services.
  - Managed Care Organizations (MCOs) that contract with the commission under this chapter shall develop a network of public and private providers of behavioral health services and ensure that adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services.
- Targeted Case Management and Mental Health Rehabilitative services for Medicaid (STAR, STAR Health, STAR Kids and STAR+PLUS) members are included in the managed care benefit package.

Assessment of Services

- Rehabilitative and TCM services may be provided to individuals with a Severe and Persistent Mental Illness (SPMI) or a Severe and Emotional Disturbance (SED), and who require services as determined by the Adults Needs and Strengths Assessment (ANSA) or Child and Adolescent Needs and Strengths Assessment (CANS).
  - **Please note:** The CANS referenced throughout this training refers to the CANS 1.0, which is a separate assessment from the CANS 2.0. For more information on the CANS 2.0, please refer to the Texas CANS 2.0 FAQ in the Texas Child and Adolescent Needs and Strengths (CANS) section of the Foster Care Texas Provider Resources webpage, https://www.FosterCareTX.com/for-providers/resources.html.
- Superior is required to utilize the Department of State Health Services (DSHS) Texas Resilience and Recovery (TRR) Utilization Management (UM) Guidelines. To review these guidelines, please visit https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual.

Provider Network

- Prospective providers can submit a network participation request at www.SuperiorHealthPlan.com/providers/become-a-provider.html.
- Participating facilities must submit a rendering provider roster to Superior to add both licensed and non-licensed providers to their current contract.
- Superior is required to perform DFPS background checks on all Foster Care providers. Providers must submit a Central Registry Check Request for Abuse/Neglect – Form 1600 for all licensed Foster Care providers.
- Superior requires that facilities and multi-specialty groups that provide Mental Health TCM and Mental Health Rehabilitative Services submit the SB58 Attestation Form **annually** as required by Senate Bill 58 of the 83rd Legislative Session.
  - The form can be found at www.SuperiorHealthPlan.com/providers/resources/forms.html, and can be submitted to ProviderCertifications@SuperiorHealthPlan.com.

Contract Requirements

- Providers are required to attest to the following prior to delivering SB58 services and on an annual basis:
  - Participating providers are trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS) assessment tools, and agree to use these tools to recommend a level of care by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system.
  - The participating provider has completed all training requirements outlined in the Texas Health and Human Services (HHS) Uniform Managed Care Manual (UMCM) Chapter 15.3 before delivering any MHR and Mental Health TCM Services. To review these requirements, please visit https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/15-3.pdf.
  - The participating entity will complete the Texas Standard Prior Authorization Request Form for all Level of Care (LOC) 4 and will submit to Superior.
    - **Please note:** This is included in the SB58 Attestation Form providers must submit annually, linked on the previous slide.

Contract Requirements

- Providers are required to attest to the following prior to delivering SB58 services and on an annual basis (continued):
  - The participating entity will provide Mental Health Rehabilitative Services and TCM using the DSHS TRR UM Guidelines and the ANSA or the CANS tools for assessing a member's needs for services.
  - The participating entity has the ability to provide covered persons with the full array of TRR services either directly or through sub-contract.
  - The participating entity is familiar with HHS' cost reporting process and will participate in this process.

Authorizations

Authorizations

- Authorization is not required for TCM and Mental Health Rehabilitative Services for participating providers.
- Services are subject to retrospective review and recoupment if documentation does not support the service billed.
- The participating entity must complete the Texas Standard Prior Authorization Request Form for all LOC 4 and will submit to Superior.

Mental Health Rehabilitative and Targeted Case Management Services

Mental Health Rehabilitation (MHR)

- Services that are individualized, age-appropriate and provide training and instructional guidance that restore an individual's functional deficits due to serious mental illness or serious emotional disturbance.
- MHR services include:
  - Crisis Intervention Services (H2011).
  - Medication Training and Support Services (H0034).
  - Psychosocial Rehabilitative Services (H2017).
  - Skills Training and Development Services (H2014).
  - Day Program for Acute Needs (H2012).

Please note: The information above and on the following slides comes from the Texas Medicaid Provider Procedures Manual (TMPPM), which is updated monthly. For the latest information, please visit https://www.tmhp.com/resources/provider-manuals/tmppm.

Mental Health Rehabilitation (MHR)

- A Medicaid provider may only bill for medically necessary MHR services that are provided face-to-face to:
  - A Medicaid-eligible person.
  - The Legally Authorized Representative (LAR) of a Medicaid-eligible person who is 21 years of age and older (on behalf of the person).
  - The LAR or primary caregiver of a Medicaid-eligible person who is 20 years of age and younger (on behalf of the person).
- Rehabilitative services delivered via group modality are limited to an 8-person maximum for adults and a 6-person maximum for children or adolescents (not including LARs or caregivers).

Mental Health Rehabilitation (MHR) Modifiers

Modifier	Description
ET	Individual crisis services
HA	Individual services for child/youth
HQ	Group services
TD	Services rendered by Registered Nurse (RN)

Mental Health Rehabilitation (MHR)

- A Medicaid provider will not be reimbursed for a MHR service:
  - Not included in the person's treatment plan (except for crisis intervention services).
  - Provided to a person receiving mental health case management services (at the same time).
  - That is not documented.
  - Provided to a person who does not meet the eligibility criteria.
  - Provided to a person who does not have a current uniform assessment (except for crisis intervention services).
  - Provided to a person who is not present, awake and participating during such service.

Mental Health Rehabilitation (MHR)

- The cost of the following activities is included in the Medicaid MHR services reimbursement rate(s) and may not be directly billed by the Medicaid provider:
  - Developing and revising the treatment plan.
  - Staffing and team meetings to discuss the provision of MHR services.
  - Monitoring and evaluating outcomes of interventions.
  - Documenting the provision of MHR services.
  - A staff member's travel time to and from a location to provide MHR services.
  - All services provided within a day program for acute needs.
  - Administering the uniform assessment to persons who are receiving MHR services.

Crisis Intervention

- Crisis intervention services are intensive community-based one-to-one services provided to persons who require services to control acute symptoms that place the person at immediate risk of hospitalization, incarceration or placement in a more restrictive treatment setting.
- According to TRR UM Guidelines, the utilization of the crisis services array is based on what is medically necessary and available during the psychiatric crisis.

Crisis Intervention

- Procedure code H2011 may be reimbursed for up to 96 units (24 hours) per calendar day in any combination according to medical necessity.

Service	Procedure Code	Modifier 1	Unit
Adult Services	H2011		15 minutes
Child and Adolescent Services	H2011	HA	15 minutes

Medication Training and Support

- Medication training and support services consist of education and guidance about medications and their possible side effects.
- Procedure code H0034 may be reimbursed for up to 8 units (2 hours) per calendar day in any combination according to medical necessity.

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Group services for adults	H0034	HQ		15 minutes
Group services for child/youth	H0034	HA	HQ	15 minutes

Medication Training and Support

- According to TRR UM Guidelines, the average monthly utilization for this service for individual and group for each LOC is the following:

TRR UM Child and Adolescent Guidelines		
LOC	Standard	High Need
1,2	0.5 hour each (ind and grp)	3.75 hours each (ind and grp)
3	0.5 hour each (ind and grp)	4.5 hours each (ind and grp)
4	0.5 hour each (ind and grp)	4.5 hours each (ind and grp)
YES Waiver	0.5 hour each (ind and grp)	4.5 hours each (ind and grp)
YC	0.5 hour each (ind and grp)	3 hours each (ind and grp)

TRR UM Adult Guidelines		
LOC	Standard	High Need
1S	1 hour (ind) 0.75 hour (grp)	1.75 hours (ind) 1.25 hours (grp)
2	1 hour (ind) 0.75 hour (grp)	1.5 hours (ind) 2.15 hours (grp)
3	1 hour (ind) 0.75 hour (grp)	1.5 hours (ind) 5 hours (grp)
4	1 hour (ind) 0.75 hour (grp)	2.5 hours (ind) 2.75 hours (grp)
TAY	1 hour (ind) 0.75 hour (grp)	1.5 hours (ind) 5 hours (grp)

Psychosocial Rehabilitative Services

- Psychosocial rehabilitative services are social, behavioral and cognitive interventions that build on strengths and focus on restoring the person's ability to develop and maintain social relationships, occupational or educational achievement and other independent living skills.
- Procedure code H2017 may be reimbursed for up to 16 units (4 hours) per calendar day, in any combination, for clients 18 years and older according to medical necessity.

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Individual services provided by RN	H2017	TD		15 minutes
Group services	H2017	HQ		15 minutes
Group services provided by RN	H2017	HQ	TD	15 minutes
Individual crisis services	H2017	ET		15 minutes

Psychosocial Rehabilitative Services

- This service is available to adults in LOC 3 and 4.
- According to TRR UM Guidelines, the average monthly utilization for this service for individual and group is the following:

TRR UM Adult Guidelines		
LOC	Standard	High Need
3	3.5 hours (ind) 2.25 hours (grp)	7 hours (ind) 8.6 hours (grp)
4	5.75 hours (ind) 2.5 hours (grp)	14.25 hours (ind) 8.6 hours (grp)

Skills Training and Development

- Skills training focuses on the improvement of communication skills, appropriate interpersonal behaviors and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers and teachers.
- Procedure code H2014 may be reimbursed for up to 16 units (4 hours) per calendar day, in any combination, according to medical necessity.

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Group services for adults	H2014	HQ		15 minutes
Individual services for child/youth	H2014	HA		15 minutes
Group services for child/youth	H2014	HA	HQ	15 minutes

Skills Training and Development

- This service is available to children in LOC 2, 3, 4, Youth Empowerment Services (YES) Waiver and Young Child (YC) and adults in LOC 1S, 2, and Transition Age Youth (TAY).
- According to TRR UM Guidelines, the average monthly utilization for this service for individual and group is the following:

TRR UM Child and Adolescent Guidelines

LOC	Standard	High Need
2, 3, 4	3 hours each (ind and grp)	6 hours each (ind and grp)
YES Waiver	3 hours each (ind and grp)	6 hours each (ind and grp)
YC	3 hours each (ind and grp)	6 hours each (ind and grp)

TRR UM Adult Guidelines

LOC	Standard	High Need
1S	2 hours (ind) 0.75 hrs (grp)	3.5 hours (ind) 5 hours (grp)
2	1 hour (ind) 1 hour (grp)	2 hours (ind) 4.25 hours (grp)
TAY	3 hours each (ind and grp)	6 hours each (ind and grp)

Day Program for Acute Needs

- Day programs for acute needs provide short term, intensive treatment to an eligible person who is 18 years of age or older and who requires multidisciplinary treatment to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.
- It is available to adults in LOC 3 and 4.
- Procedure code H2012 may be reimbursed for up to 6 units (4.5 to 6 hours) per calendar day, in any combination, for clients 18 and older.

Service	Procedure Code	Unit
Adult day program for acute needs	H2012	45-60 minutes

Targeted Case Management (TCM)

- Targeted Case Management (T1017):
  - Assist persons in gaining access to needed medical, social/behavioral, educational and other services and supports.
  - Include monitoring of service effectiveness as frequently as necessary (at least annually).
  - TCM is a Medicaid billable service provided separate from Superior Service Coordination.
    - Service Coordinators coordinate with providers to ensure integration of behavioral and physical health needs of enrollees.
    - Service Coordinators refer non-eligible enrollees to Local Mental Health Authorities (LMHAs) that can provide indigent mental health care.

Targeted Case Management (TCM)

- The following activities are included in the Mental Health Targeted Case Management (MHTCM) rate and will not be reimbursed separately:
  - Documenting the provision of MHTCM services.
  - Ongoing administration of the Uniform Assessment to determine amount, duration and type of MHTCM.
  - Travel time required to provide MHTCM services at a location not owned, operated or under arrangement with the provider.
- MHTCM is not payable when delivered on the same day as psychosocial rehabilitative services.

Targeted Case Management (TCM)

- Routine case management services are primarily office-based activities that assist a person, caregiver or LAR in obtaining and coordinating access to necessary care and services appropriate to the person's needs.
  - Routine Case Management is available to adults in LOC 1M, 1S and 2, and also to children.
- Intensive case management incorporates a wraparound approach to care planning and treatment plan implementation. The wraparound process is a strengths-based course of action involving a child or youth (20 years of age and younger) and their family
  - Intensive case management is available to children in Level of Care (LOC) 4, YES Waiver, and YC.
  - It is not available to adults.

Routine Case Management

- According to TRR UM Guidelines, the average monthly utilization for routine case management is the following:

TRR UM Child and Adolescent Guidelines		
LOC	Standard	High Need
1	0.5 hour	1 hour
2, YC	1 hour	2 hours
3	1 hour	6 hours
4	2 hours	6 hours
YES Waiver	4 hours	8 hours

TRR UM Adult Guidelines		
LOC	Standard	High Need
1M	0.5 hour	2.15 hours
1S	0.75 hour	1.25 hours
2	0.25 hour	1 hour

Intensive Case Management

- According to TRR UM Guidelines, the average monthly utilization for intensive case management is the following:

TRR UM Child and Adolescent Guidelines		
LOC	Standard	High Need
4	4 hours	8 hours
YES Waiver	4 hours	8 hours
YC	3.75 hours	6.25 hours

Targeted Case Management Modifiers

Modifier	Description
TF	Routine Case Management
TG	Intensive Case Management
HA	Child/Adolescent Program
HZ	Funded by criminal justice agency

Please note: According to TRR UM Guidelines, routine case management and intensive case management cannot be provided concurrently.

Service Codes and Modifiers

- Procedure code T1017 may be reimbursed up to 32 units (8 hours) per calendar day.

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Routine Mental Health Target Case Management (Adult)	T1017	TF		15 minutes
Routine Case Management (Child and Adolescent)	T1017	HA	TF	15 minutes
Intensive Case Management (Child and Adolescent)	T1017	HA	TG	15 minutes

Claims Filing

Claims Filing

- Claims must be filed within 95 days from the Date of Services (DOS).
- A provider may submit a corrected claim or claim appeal within 120 days from the date of Explanation of Payment (EOP) or denial is issued.
- Providers should include a copy of the EOP when other insurance is involved.
- Claims must be:
  - Completed in accordance with Texas Medicaid & Healthcare Partnership (TMHP) billing guidelines.
  - Filed on a red CMS 1500 or UB-04 form. These forms can be located on Superior's Provider Forms webpage, www.SuperiorHealthPlan.com/providers/resources/forms.html.
  - Filed electronically through a clearinghouse.
  - Filed directly through the Secure Provider Portal, Provider.SuperiorHealthPlan.com.
- 24 (I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) National Provider Identifier (NPI) are all required when billing Superior claims.

Submitting Claims

- Secure Provider Portal: Provider.SuperiorHealthPlan.com
- Electronic Claims:
  - View a list of Superior's Trading Partners:
    - www.SuperiorHealthPlan.com/providers/resources/electronic-transactions.html
  - Superior Emdeon ID: 68068
- Paper Claims - Initial

  Superior HealthPlan
  Behavioral Health Claims
  P.O. Box 6300
  Farmington, MO 63640-6806
- Paper Claims – Appeals and Corrected Claims

  Superior HealthPlan
  Behavioral Health Appeals
  P.O. Box 6000
  Farmington, MO 63640-3809

Corrected Claims vs. Appeals

- Corrected Claim
  - A corrected claim is a resubmission of an original clean claim that was previously adjudicated and included all elements necessary to process the claim, but one or more elements included in the original claims submission required corrections.
- Claim Appeal
  - A claim that has been previously adjudicated as a clean claim and the provider is appealing the disposition through written notification with supporting documentation to Superior.

Claims Filing Deadlines

- First Time Claim Submission
  - 95 days from the Date of Service
- Adjusted or Corrected Claims
  - 120 days from the date of EOP or denial is issued
- Claims Reconsiderations and Appeals
  - 120 days from the date of EOP or denial is issued

SB58 Claim Filing Tips

- Services rendered by licensed providers must be submitted with the rendering provider NPI/Taxonomy in box 24J of the CMS 1500 claim form.
- Services rendered by a non-licensed provider should be submitted with the facility or group NPI/Taxonomy in box 24J and box 33 of the CMS 1500 claim form.
- Modifiers must be submitted in appropriate modifier position, as indicated.
- Services billed with a modifier HZ (Criminal Justice) will be denied, as these services are funded by the state.

Provider Resources

PaySpan Health

- Superior has partnered with PaySpan Health to offer expanded claim payment services to include:
  - Electronic Claim Payments/Funds Transfers (EFTs).
  - Online Remittance advices (Electronic Remittance Advice [ERAs]/EOPs).
  - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System.
- Register at www.PaySpanHealth.com.
- For more information, contact PaySpan:
  - **Phone:** 1-877-331-7154
  - **Email:** ProviderSupport@PaySpanHealth.com

Pharmacy Benefits

- The Pharmacy Benefit Manager (PBM):
  - Is responsible for timely and accurate payment of pharmacy claims.
  - Provides the pharmacy claim adjudication platform.
  - Is responsible for adjudicating claims according to Vendor Drug Program (VDP) formulary.
  - Provides pharmacy network for Superior members.
  - Is responsible for Prior Authorization (PA) of outpatient prescriptions, as applicable.
- Providers should reference the Vendor Drug Program (VDP) formulary for all LOB in Medicaid (including STAR Health) and CHIP.
- The VDP formulary contains preferred drugs for Medicaid and has a preferred drug list. Preferred drugs do not require a prior authorization for that product but may be subject to clinical edits and or quantity limits. There are no non-preferred products in CHIP.
- PDL, clinical edit requirements and quantity limits are available on Superior's Pharmacy webpage at www.SuperiorHealthPlan.com/providers/resources/pharmacy.html.
- Providers may use Epocrates. For more information, visit www.Epocrates.com.

Pharmacy Contact Information

- General Questions and Concerns
  - Phone: 1-800-218-7453, ext. 22272
  - Fax: 1-866-683-5631
  - E-forms: www.SuperiorHealthPlan.com/contact-us

- Prior authorization for clinician administered drugs (Superior Prior Authorization Department)
  - PA Requests Phone: 1-800-218-7453, ext. 22272
  - PA Requests Fax: 1-866-683-5631
  - Superior also processes PA for Synagis and Makena

- Appeals (Superior Appeal Department)
  - Appeals Requests Phone: 1-877-398-9461, ext. 22168
  - Appeals Requests Fax: 1-866-918-2266

- Outpatient Rx (Pharmacy Services)
  - PA Requests Phone: 1-866-768-7147
  - PA Requests Fax: 1-833-423-2523

Superior's Medical Ride Program by SafeRide

- Effective June 1, 2021, Superior began serving Medicaid members who have no other means of transportation by providing SafeRide for non-emergent medical, behavioral, dental, substance use disorder or pharmacy appointments.
  - Member will need to call SafeRide at least two business days before the appointment at 1-855-932-2318.
  - Member will need to have Medicaid ID and appointment information ready.
  - Member will receive reminders to be ready for their ride.
- Not included in Superior's Medical Ride Program
  - Emergency ambulance – call 911.
  - Rides to services not covered by Superior.
  - Rides to providers who are not in Superior's network.
  - Rides that are not for a health-care visit, such as to the grocery store, shopping mall or movie theater.

Superior HealthPlan Departments

Behavioral Health Care Management

- Superior has experienced Registered Nurses (RNs), Licensed Professional Counselors (LPCs) and Licensed Clinical Social Workers (LCSWs) who can assist members in coordinating all aspects of their care.
- Care management services are available for any members.
- Levels of care management include:
  - **Care Coordination** – Lowest level; mostly short term needs, social assistance, stable chronic conditions.
  - **Care Management** – Intermediate needs; may require additional time or resources to ensure member's needs are addressed.
  - **Complex Care Management** – Significant illness burden and complexity; members require longer term, ongoing assistance to address care gaps and service needs.

Service Coordination

- Superior's Service Coordination department can assist with:
  - Case management services and assistance with scheduling outpatient appointments.
  - Face-to-face visits with enrollees in inpatient settings.
  - Assisting inpatient facilities with discharge planning.
  - Assisting with 7-day follow-up.
  - Providing licensed clinicians that are available for enrollees with greater needs.
  - Assisting enrollees with obtaining resources in their area.

Utilization Management

- Superior's Utilization Management department is made up of licensed counselors who can assist with:
  - Monitoring the delivery of services through retrospective review.
  - Giving feedback on quality of care and compliance concerns.
  - Assisting with questions regarding the TRR UM Guidelines and the Texas Administrative Code (TAC) requirements of MHR and TCM.

Provider Services

- Superior's Provider Services department can assist with:
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
- For claims-related questions, please have your claim number, TIN and other pertinent information available as HIPAA validation will occur.
- Contact Provider Services, Monday – Friday, 8:00am – 6:00pm CDT:
  - 1-877-391-5921

Account Management

- Superior's field staff can assist with:
  - Face-to-face orientations.
  - Secure Provider Portal training (Provider.SuperiorHealthPlan.com).
  - Office visits to review ongoing trends.
- Superior Account Management offers targeted presentations depending on the type of services you provide.

Please note: To find contact information for your Account Manager, please visit www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html.

Questions and Answers

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